

**Medicare-Medicaid Reimbursement Policies:
Effects on Teaching Hospitals, Physician
Distribution, and Foreign Medical Graduates: Social
Security Studies, Interim Report (1975)**

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MEDICARE-MEDICAID REIMBURSEMENT POLICIES:
**Effects on Teaching Hospitals, Physician
Distribution, and Foreign Medical Graduates**

Social Security Studies

Interim Report

March 1975

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NOTICE

This is the interim report of a project undertaken with the approval of the Council of the Institute of Medicine, National Academy of Sciences. Such approval manifests the judgment that the project is of national importance and appropriate both to the purposes and professional resources of the Institute of Medicine. A final report is scheduled for publication in March 1976.

The members of the committee appointed to conduct the project and prepare the report were selected for recognized competence and with due consideration for the balance of disciplines appropriate to the project. Responsibility for the substantive aspects of the report rests with that committee.

Each report issuing from a study committee of the Institute of Medicine is reviewed by an independent group of qualified individuals according to procedures established and monitored by the National Academy of Sciences. Only upon satisfactory completion of the review process is distribution of a report approved.

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of medical and other professions for the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 Congressional charter responsibility to be an advisor to the Federal Government, and its own initiative in identifying issues of medical care, research and education.

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NATIONAL ACADEMY OF SCIENCES

2101 CONSTITUTION AVENUE
WASHINGTON, D. C. 20418

INSTITUTE OF MEDICINE
OFFICE OF THE PRESIDENT

March 31, 1975

The Honorable James B. Cardwell
Commissioner of Social Security
Baltimore, Maryland 21235

Dear Mr. Cardwell:

I am pleased to present to the Social Security Administration an interim report on the studies undertaken by the Institute of Medicine of the National Academy of Sciences, pursuant to Section 15(c) of the Social Security Act Amendments of 1973 (P.L. 93-233). These provisions requested the Secretary of Health, Education, and Welfare to arrange for studies concerning (A) appropriate and equitable methods of reimbursement for physicians' services under Titles XVIII and XIX of the Social Security Act in hospitals which have a teaching program approved as specified in section 1861(b)(6) of such Act, (B) the extent to which funds expended under such titles are supporting the training of medical specialties which are in excess supply, (C) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty, (D) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates, and (E) the existing and appropriate role that part of such funds which are expended to meet in whole or in part the cost of salaries of interns and residents in teaching programs approved as specified in section 1861(b)(6) of such Act. A letter agreement was signed with the Social Security Administration on June 27, 1974 and a final contract was entered into on November 26, 1974.

The enclosed interim report is a progress report which includes background information; legislative and administrative history of the issues related to the studies; and a description of the methods and data instruments to be used in the studies.

We shall be glad to discuss this interim report in greater detail with you and your staff.

Sincerely yours,



Donald S. Fredrickson, M.D.
President

Enclosure

NATIONAL ACADEMY OF SCIENCES

2101 CONSTITUTION AVENUE
WASHINGTON, D. C. 20418

INSTITUTE OF MEDICINE

OFFICE OF THE PRESIDENT

March 31, 1975

The Honorable Caspar W. Weinberger
Secretary of Health, Education and
Welfare
Washington, D. C. 20201

My dear Mr. Secretary:

I am pleased to present to the Department of Health, Education, and Welfare an interim report on the studies undertaken by the Institute of Medicine of the National Academy of Sciences, pursuant to Section 15(c) of the Social Security Act Amendments of 1973 (P.L. 93-233). These provisions requested the Secretary of Health, Education, and Welfare to arrange for studies concerning (A) appropriate and equitable methods of reimbursement for physicians' services under Titles XVIII and XIX of the Social Security Act in hospitals which have a teaching program approved as specified in section 1861(b)(6) of such Act, (B) the extent to which funds expended under such titles are supporting the training of medical specialties which are in excess supply, (C) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty, (D) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates, and (E) the existing and appropriate role that part of such funds which are expended to meet in whole or in part the cost of salaries of interns and residents in teaching programs approved as specified in section 1861 (b)(6) of such Act. A letter agreement was signed with the Social Security Administration on June 27, 1974 and a final contract was entered into on November 26, 1974.

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NATIONAL ACADEMY OF SCIENCES

2101 CONSTITUTION AVENUE
WASHINGTON, D. C. 20418

INSTITUTE OF MEDICINE

OFFICE OF THE PRESIDENT

March 31, 1975

The Honorable Russell B. Long
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20501

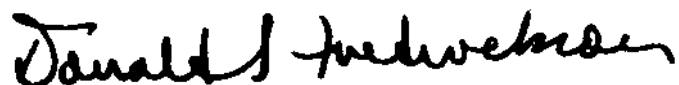
Dear Mr. Chairman:

I am pleased to present to the Committee on Finance an interim report on the studies undertaken by the Institute of Medicine of the National Academy of Sciences, pursuant to Section 15(c) of the Social Security Act Amendments of 1973 (P.L. 93-233). These provisions requested the Secretary of Health, Education, and Welfare to arrange for studies concerning (A) appropriate and equitable methods of reimbursement for physicians' services under Titles XVIII and XIX of the Social Security Act in hospitals which have a teaching program approved as specified in section 1861(b)(6) of such Act, (B) the extent to which funds expended under such titles are supporting the training of medical specialties which are in excess supply, (C) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty, (D) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates, and (E) the existing and appropriate role that part of such funds which are expended to meet in whole or in part the cost of salaries of interns and residents in teaching programs approved as specified in section 1861(b)(6) of such Act. A letter agreement was signed with the Social Security Administration on June 27, 1974 and a final contract was entered into on November 26, 1974.

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Sincerely yours,



Donald S. Fredrickson, M.D.
President

Enclosure

NATIONAL ACADEMY OF SCIENCES

2101 CONSTITUTION AVENUE

WASHINGTON, D. C. 20418

INSTITUTE OF MEDICINE

OFFICE OF THE PRESIDENT

March 31, 1975

The Honorable Al Ullman
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am pleased to present to the Committee on Ways and Means an interim report on the studies undertaken by the Institute of Medicine of the National Academy of Sciences, pursuant to Section 15(c) of the Social Security Act Amendments of 1973 (P.L. 93-233). These provisions requested the Secretary of Health, Education, and Welfare to arrange for studies concerning (A) appropriate and equitable methods of reimbursement for physicians' services under Titles XVIII and XIX of the Social Security Act in hospitals which have a teaching program approved as specified in section 1861(b)(6) of such Act, (B) the extent to which funds expended under such titles are supporting the training of medical specialties which are in excess supply, (C) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty, (D) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates, and (E) the existing and appropriate role that part of such funds which are expended to meet in whole or in part the cost of salaries of interns and residents in teaching programs approved as specified in section 1861(b)(6) of such Act. A letter agreement was signed with the Social Security Administration on June 27, 1974 and a final contract was entered into on November 26, 1974.

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We shall be glad to discuss this interim report in greater detail with the members and staff of your committee.

Sincerely yours,



Donald S. Fredrickson, M.D.
President

Enclosure

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Chapter 1

INTRODUCTION

In 1973, congressional concern about Medicare and Medicaid reimbursement policies led to legislation calling for a study to be conducted by the National Academy of Sciences. Section 15c of the Social Security Amendments of that year stated:

The Secretary of Health, Education, and Welfare shall arrange for the conduct of a study or studies concerning (A) appropriate and equitable methods of reimbursement for physicians' services under Titles XVIII and XIX of the Social Security Act in hospitals which have a teaching program approved as specified in section 1861 (b) (6) of such Act, (B) the extent to which funds expended under such titles are supporting the training of medical specialties which are in excess supply, (C) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty, (D) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates, and (E) the existing and appropriate role that part of such funds which are expended to meet in whole or in part the cost of salaries of interns and residents in teaching programs approved as specified in section 1861 (b) (6) of such Act.^{1/}

The specific origins of this charge can be traced to the Social Security Amendments of 1965, which established the Medicare and Medicaid programs, and the problems that arose over the payment of physicians in teaching hospitals. The original legislation and subsequent regulations and guidelines were structured for reimbursement of physicians in a non-teaching hospital setting, where their main function is to provide patient care, and their services to patients are easily documented. The legislation did not recognize the numerous responsibilities of physicians in a teaching hospital setting or the complexity of payment arrangements by which these physicians who teach, care for patients, and conduct research, are reimbursed.

Reimbursement for physicians' services in teaching hospitals was the catalyst for this study. In addition, the congressional charge directs the National Academy of Sciences to address questions about the influence of Medicare and Medicaid funds on the specialty and geographic distribution of physicians, and on the training and distribution of foreign medical graduates.

MEDICARE

Funded primarily by the federal government, Medicare is a social insurance program which provides health insurance benefits to most people over sixty-five in the nation, certain severely disabled persons, and patients with chronic renal diseases. It is administered by the Bureau of Health Insurance of the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW). Benefits are provided through two separate parts of the program.

Part A

Part A, hospital insurance, covers inpatient hospital services, services in extended care facilities, and home health services. As part of inpatient hospital costs, Part A covers teaching and supervisory activities of certain hospital-based physicians and salaries of house officers. Part A does not cover professional services provided to patients by physicians other than interns and residents.

Part A is financed through payroll deductions. No premium payments are required during periods of eligibility for benefits. Reimbursement for care furnished to beneficiaries is made directly to "providers of service" -- hospitals, skilled nursing facilities, and home health agencies.

The law allows for some administrative responsibilities - principally reimbursement of institutions - to be contracted out to "intermediaries" which act on behalf of the federal government. State health departments act on behalf of the federal government by determining whether institutions which apply meet the federally established standards for participation. Providers of service may elect to deal directly with SSA, rather than with an intermediary.

Part B

Part B, medical insurance, covers outpatient hospital services, physician services regardless of where they are performed, independent laboratory services, home health visits, and a variety of other services. It is financed by monthly premiums paid by those enrolled (an individual may elect not to be covered), with federal general revenues paying for more than half the cost of the program.

Under Part B, the beneficiary may be reimbursed directly; reimbursement is based on an itemized bill.

The right to claim benefits can be assigned by the beneficiary to the physician, in which case the physician is reimbursed directly. If the physician accepts assignment, he must accept Medicare's determination of the "reasonable charge" for his services. If he does not accept assignment, the physician's charge to the patient may be higher than Medicare's determination of a reasonable charge. As under Part A, private insurers or carriers act as agents for the federal government.

Reimbursement Determination under Medicare

In general, Medicare's reimbursement policy was based on approaches widely used by private insurers when the program was enacted in 1965. For the most part, services of providers are covered under Part A, and reimbursement is based on "reasonable costs." Services of others are covered under Part B and reimbursement is based on reasonable charges. However, some services furnished by providers are covered under Part B; for example, outpatient hospital services and home health services that do not require prior hospitalization. These Part B services furnished by a provider are reimbursed on the basis of cost rather than charges, and the payments are made by the Part A intermediary rather than the Part B carrier.

In the original legislation, reasonable cost was not explicitly defined. A guiding principle was that Medicare should pay neither more nor less than the actual cost of furnishing services to beneficiaries; Medicare payments were not to subsidize the care of other patients, and other patients were not to subsidize the care of Medicare patients.

Reimbursements are based on estimates, and final determination and payment of costs is made at the end of an accounting period. Retroactive determination of costs has been criticized on the grounds that it contributes to inflation of health care costs. Amendments to the Medicare law have authorized experiments with reimbursement methods designed to provide incentives for cost control. Cost control provisions have also been added under the regular reimbursement formula by provisions in the Social Security Act Amendments of 1972.

Part B reimbursement is based on reasonable charges which is a variation of the well-established private health insurance industry practice of paying for physicians' services on the basis of usual and customary charges. Medicare determination of reasonable charges is based on "customary charges" and "prevailing charges." An individual physician's customary charge is the fee he regularly bills for a specific service. Prevailing charges are those fees generally billed by physicians in a specific geographic area. These impose a ceiling on the customary charge that may be considered reasonable. Generally speaking, the individual physician's customary charge will be honored as long as it does not exceed the prevailing charge in the geographic area for the same service.

The prevailing charge limit is statistically determined. Originally, it was established at the 83rd percentile of customary charges in a geographic area. Later, in a cost control move, the prevailing limit was lowered to the 75th percentile. Legislation passed in 1972 further modified the prevailing charge concept by specifying that future increases would not be allowed beyond what is permitted by an economic index designed to reflect increases in the physician's cost of operation.

Since geographic areas are used to determine prevailing limits, the fee levels in a geographic area are reflected in Medicare reimbursements. In areas with many physicians, for example, if fees are high in relation to another area, Medicare has reinforced the situation. A critical factor is the geographic area used for determining prevailing charges. For example, if the greater Los Angeles metropolitan area is used for calculating the prevailing limit, it will be different from the limit established if Beverly Hills and Watts are considered separate geographic areas.

Implications of the Division of Medicare into Two Parts

The separation of the Medicare program into Part A and Part B results in several complications, most significant of which for this study is reimbursement for physicians' services. Professional patient care services provided by physicians are excluded from Part A and covered under Part B, except for services furnished by interns and residents. In most cases, house officer services are covered on a cost basis, and when performed in the course of an approved training program, they are covered, like other hospital services, under Part A.

A separate rule applies to interns and residents who are not in approved training programs. Their services, as well as those of moonlighting residents and physicians with limited licenses, are covered on a cost basis and the hospital is reimbursed under Part B.*

Administrative and teaching activities of physicians are covered only under Part A on a cost basis. This rule is discussed below.

Hospital-Based Physicians

The coverage only under Part B of physicians' services to individual patients has led to serious complications in situations involving hospital-based physicians, whose care to patients is centered in a hospital. Such physicians may be salaried by the hospital or may operate under a variety of financial arrangements whereby the hospital or medical service plan bills for their services.

*Services of fully licensed interns and residents are reimbursed under Part B on a reasonable charge basis when the services are not rendered in a provider setting and the physician is not compensated by a provider.

After enactment of Medicare, there was particular controversy over reimbursement of hospital-based physicians such as radiologists, pathologists, and anesthesiologists. Under arrangements formerly in widespread use, many hospitals billed for services furnished in such departments, and Blue Cross plans typically covered these services entirely as hospital services.

An example of the kinds of problems that arose had to do with combined billing. Medicare regulations stipulated a separation of reimbursement for the medical components of personal patient care services furnished by the hospital-based physician from the reimbursement of hospital costs of care (such as cost of x-rays). Formerly the entire service was often billed for and reimbursed as a single entity.

The two parts of what had been viewed as a single service were reimbursed on different bases, and coverage was subject to different deductible and coinsurance rules. Many hospital-based physicians who had not done so before began billing patients directly for their own component of services, and in these instances, Medicare had difficulty ascertaining whether the total amount reimbursed separately exceeded the amount that would have been paid had there been a single combined bill. Patients had difficulty understanding the separation of a single service into separate physician and hospital bills.

A partial solution was brought about by an amendment to the law under which hospital-based services could be treated as though they were entirely covered under Part A if the physician and hospital would agree on combined billing for the total services.

Teaching Physicians

The division into Part A and Part B remains a problem for reimbursing teaching physicians in a hospital setting who both teach and care for patients. Medicare reimbursement policy for Part A recognizes part of the cost of education conducted on hospital premises as a cost appropriately to be borne by the Medicare program. Thus, the stipends of interns and residents in approved training programs are covered under Part A with no need to determine what portion of their stipend represents a cost of education or what portion represents a patient care cost.

However, there are serious difficulties in determining the amounts payable under each part of the program to teaching physicians who involve interns and residents in the care of their patients. Teaching and supervisory activities are covered under Part A only; medical services of the physician to the patient are covered under Part B only. Often the physician simultaneously teaches and cares for patients. He frequently provides these services in a team setting with interns and residents present and assisting. The difficulties in formulating workable rules for determining reimbursement in a teaching setting, complicated by the variety of financial arrangements between physicians and teaching hospitals, led to the legislation calling for this study.

Medicare Commitment to Pay Medical Education Costs

From the beginning, Part A of the Medicare law has authorized reimbursement for the cost of approved training programs, including internship and residency programs, carried out in hospitals. Medicare reimbursement is made to the hospital on a cost basis and includes both the stipends of interns and residents and the compensation paid by the hospital to physicians for their teaching and supervisory services.

The policy of paying for the cost of approved training programs under Medicare grew out of the fact that Congress had generally endorsed the American Hospital Association's Principles of Payment as a guide to the establishment of cost reimbursement under Medicare.

In determining reasonable costs, a reasonable amount for medical, nursing, and other education not reimbursed through tuition or through scholarships, grants, and other community sources is a legitimate inclusion in the interests of continuing to upgrade the quality of services to the community.^{2/}

In contrast, the original Medicare law did not specifically address the question of coverage of physicians' services to patients in a teaching setting. The policy adopted was that payment could be made under Part B for direct medical care provided to a beneficiary by his physician if the physician provided "personal and identifiable" services to patients, even though payments for the teaching and supervisory functions of the physician and the salaries of interns and residents were reimbursed under Part A.

Documenting teaching and patient care activities of physicians in a teaching hospital proved difficult. In many cases questionable payments resulted, usually because of misunderstandings in determining and documenting the conditions required for a teaching physician to be eligible for payment under Part B. There were considerable problems in claims review and verification, and in resolving billing and payment details.

Beginning in 1969, SSA issued a series of instructions to provide a more explicit policy and to obtain a clearer and more uniform understanding of the policy. Nevertheless, congressional attention had been called to the complications of trying to apply the different reimbursement policies of Parts A and B to what was essentially a joint activity - the concurrent teaching and patient care responsibilities of physicians. The Ninety-First and Ninety-Second Congresses devoted considerable attention to this subject.

MEDICAID

Medicaid is a public assistance program designed to provide health care services to low-income individuals and families. It is financed by

federal and state general revenues. State enactment is necessary before the program becomes available to residents of a particular state. Eligibility for benefits is based on tests of income and assets and on categories tied to the Supplemental Security Program ^{3/} (for the aged, blind, and disabled) and public assistance programs.

The low-income aged and disabled can be eligible for both Medicare and Medicaid. Medicaid may pay the Part B premiums and the Medicare deductibles and coinsurance, and may provide additional services.

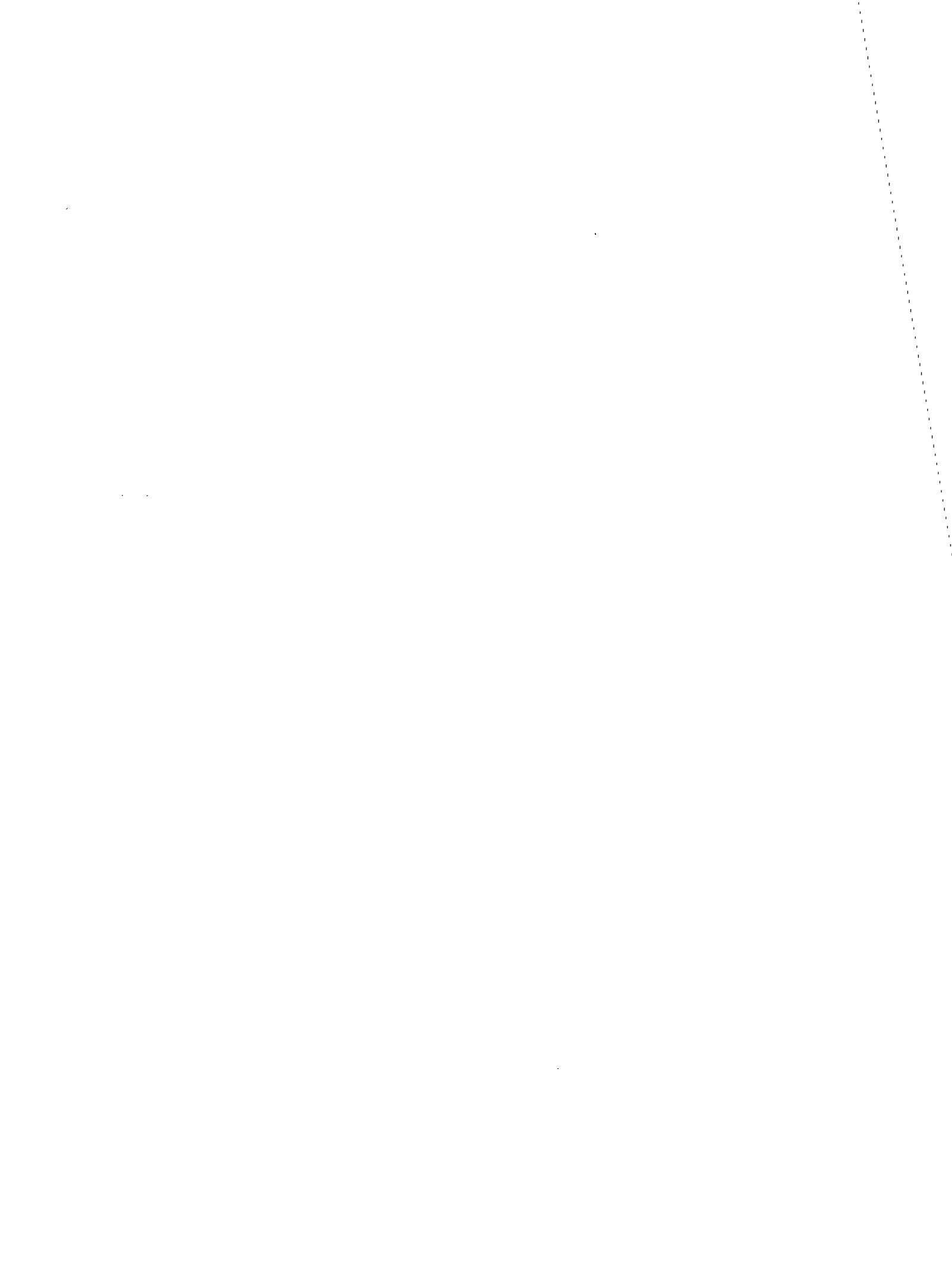
Medicaid is administered by the state after enactment. Some states use fiscal agents; others administer the program directly. The federal government matches state payments for eligible individuals and services. Amounts matched are based on the average per capita income of the state and range from 50 to 83 percent of program expenditures.

Benefits vary from state to state and can cover services beyond the scope of Medicare to include additional skilled nursing home care, intermediate care, prescription drugs, and dental care.

Medicaid Reimbursement

Medicaid originally followed the Medicare principles covering cost reimbursement for hospital care. The Social Security Act Amendments of 1972, however, permit the states to depart from the Medicare principles as long as the result is to reimburse hospitals on a cost-related basis. Several states with hospital rate setting commissions have now imposed the rates set by the states instead of the Medicare retroactive reasonable costs method.

Amounts paid for physicians' services, including the services of teaching physicians, are determined by the state and differ from state to state. In some states physicians salaried by the state university medical schools or state-owned hospitals cannot bill fees under Medicaid. Some states follow the Medicare practice of payment to physicians at the 75th percentile of prevailing charges; others follow private insurance policies, with fees at about the 90th percentile of prevailing charges. Others impose a fee schedule well below the 75th percentile; in these states, serious problems of access to physicians' services have been encountered.



Chapter 2

PATIENT CARE AND EDUCATION IN TEACHING HOSPITALS

The Social Security Act Amendments of 1973 include the provision that:

The Secretary of Health, Education, and Welfare shall arrange for the conduct of a study or studies concerning... appropriate and equitable methods of reimbursement for physicians' services under Titles XVIII and XIX of the Social Security Act in hospitals which have a teaching program approved as specified in such Act...the existing and appropriate role that part of such funds which are extended to meet in whole or in part the cost of salaries of interns and residents in teaching programs approved as specified in the Act.

In response to this part of the congressional charge, the study group is examining the organizational and financial arrangements of teaching hospitals, patient care arrangements in teaching hospitals, and methods of compensation of teaching physicians and house officers (interns, residents, and fellows).

CHARACTERISTICS OF TEACHING HOSPITALS

Some 1,500 of the over 7,000 hospitals in the United States which provide inpatient and outpatient care sponsor an internship or residency training program approved by the American Medical Association (AMA), the American Osteopathic Association (AOA), or the American Dental Association (ADA), and therefore are teaching hospitals as defined in the Social Security Act.

Although it is difficult to generalize about all teaching hospitals, several characteristics distinguish them from non-teaching hospitals. Teaching hospitals accept responsibility not only for patient care, but also for supervision and training of house officers and other health professionals. Teaching hospitals often serve as the clinical training base for undergraduate medical students, and are the site of biomedical research programs. In contrast, non-teaching hospitals provide no formal graduate medical education.

In the teaching setting, then, the teaching physician may combine patient care, teaching, and research activities. Under supervision of a physician, house officers also are involved in patient care, education, and research. As their training progresses, they assume greater responsibility for all activities.

Many urban teaching hospitals have large outpatient departments that serve as the only source of medical care for many Medicare and Medicaid recipients in a region. Many municipal and county hospitals, such as Bellevue in New York, Charity in New Orleans, and Los Angeles County are major teaching hospitals, and often are the primary source of all inpatient and outpatient care for large population groups. In addition, teaching hospitals often provide highly technical specialty services for large geographic areas or states. Many teaching hospitals are the sites of federally sponsored community health center programs, including community mental health centers, neighborhood health centers, and comprehensive children and youth centers. In contrast, non-teaching hospitals seldom furnish extensive outpatient services other than emergency room care, and rarely serve as regional centers for tertiary care.

Teaching hospitals range from institutions which sponsor one or two residency programs and which are similar to non-teaching hospitals, to institutions with 20 or more graduate programs; comprehensive inpatient and outpatient services; burn, trauma, open heart, and renal dialysis centers; biomedical research programs; undergraduate medical education programs; nurse and allied health training programs; and neighborhood health center programs. A teaching hospital may be an acute general hospital, a specialty hospital (orthopedics, children diseases), a long-term care institution, or a psychiatric institution.

Ownership arrangements of teaching hospitals include nonprofit community-based hospitals, private nonprofit university hospitals, nonprofit church-owned hospitals, municipal and county hospitals, state hospitals, and federal hospitals, including Veterans Administration hospitals.

Funding sources for inpatient and outpatient and professional physicians' services in the teaching setting may be quite different from those in a non-teaching hospital. Medical staff arrangements in teaching institutions vary, and differ from many non-teaching hospitals where there are usually no or only a few salaried physicians on the hospital staff. The teaching hospital, in contrast, has attending and/or teaching physicians, who may work either on a salary or fee basis, or a combination, and salaried house staff. Teaching physicians may be paid by the hospital or medical school, or both; receive partial salaries from these institutions and compensation from patient care fees; receive salary plus medical service plan income; or, as volunteers, receive no salary.

Payment for Patient Care in a Teaching Setting

The compensation of teaching physicians and house officers raises fundamental public policy questions about the sources of support for graduate medical

education, equity of payment for professional services to patients in relation to the type of service, and the stated objectives of Medicare and Medicaid to provide quality medical care to the elderly and to the disabled, low-income, and medically or categorically needy persons.

The history of Part B suggests that the model of health care delivery on which payment for physician charges would be based was that of the independent, private practitioner. There is no indication that the special characteristics of health care delivery in the teaching setting were considered as the law was being written.

For instance, in non-teaching settings, patients usually are cared for by their own physician, and although he may use other specialists as consultants, he generally makes all medical decisions and is legally responsible for them. Or, the patient may be referred to a specialist who admits and treats him, and thus assumes responsibility for making decisions. In either case, responsibility for making decisions about the patient's treatment is clearly that of the attending physician, and Medicare pays the physician fees under Part B.

In a teaching setting, although the attending physician may delegate some responsibility for patient care, he retains legal responsibility for the patient. Since shared responsibility is the basis of graduate medical education, the issue of Medicare reimbursement for teaching physician services has focused, since 1969, on definition of the circumstances under which a teaching physician may be paid a fee for his medical services which does not duplicate other reimbursement. As SSA policy has evolved, criteria required for payment under Part B have come to resemble those which exist in the non-teaching setting.

LEGISLATIVE HISTORY

General Accounting Office (GAO) Study

In spring of 1969, the Senate Finance Committee directed the General Accounting Office to review Medicare payments for physician services at Chicago's Cook County Hospital, where there was evidence of questionable payment for Part B services. The study was expanded to include six teaching hospitals (five were public institutions), and more instances of questionable payments were found. In a sample at one hospital, GAO found in almost all cases that professional services had been furnished by residents with only limited involvement of the attending physician in whose names the services had been billed. This was an extreme case, but GAO called the problem "widespread and significant" ^{4/} and attributed the difficulties to a "reimbursement system that is neither easily understood nor readily susceptible to effective controls." ^{5/}

Following the GAO report, SSA suspended payment for physician services at several teaching hospitals and attempted to correct the situation.

Hospitals argued that the rules for payment were unclear, and had only recently been issued under Intermediary Letter 372 (IL 372). Suspensions were lifted and payments resumed in a particular hospital after a determination was made that the coverage and billing requirements were understood and would be followed.

Intermediary Letter 372

The evidence of earlier SSA studies led SSA to try to clarify previous regulations. One of the most significant documents was IL 372, "Part B Payments for Services of Supervising Physicians in a Teaching Setting," which was published in April, 1969, and which is still in effect. IL 372 outlined requirements for coverage and reimbursement of personal and identifiable patient care services of physicians in a teaching setting. Before IL 372 was published, there were no clear guidelines for reimbursement. IL 372 defined criteria as:

The physician must be the patient's attending physician. He must... personally examine the patient...perform...or supervise treatment...be recognized by the patient as his personal physician...Performance of the activities above must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician.^{6/}

SSA instructed carriers not to pay bills for services of teaching physicians unless the chief of the department or service involved certified each month that each of the billed services met the requirements for payment; or, bills were to be signed by the attending physician, as his own certification that the requirements had been met. All claims were subject to carrier audit and verification by checks of patient records and examination of admission, progress, and discharge notes. Documentation was a source of irritation to physicians and hospitals, and the procedures were viewed as time-consuming and not relevant either to the quality of patient care or to the education process.

Section 227 and Proposed Regulations

IL 372 defined the requirements for reimbursing physicians for patient care services in a teaching setting. Section 227^{7/} of the Social Security Amendments of 1972 provided for reimbursement for services of teaching physicians to a nonprivate Medicare patient, as defined in regulations, to be made on the basis of reasonable cost. Fee-for-service reimbursement under Part B for services to private patients, as defined in regulations, was authorized to continue. The intent of Section 227 was to simplify the determination of when fees under Part B could be paid and to offer the alternative of cost reimbursement.

It was designed to remedy the problems that had arisen in trying to reimburse the separate parts of physicians' activities under Part A and Part B.*

In its report on the legislation, the Senate Finance Committee expressed the view that:

In large teaching hospitals with an almost exclusively charity clientele...since the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than on a fee-for-service basis under the supplementary medical insurance program.^{8/}

On the other hand, teaching institutions questioned this premise and emphasized that necessary personal professional patient care services were being provided to patients for the benefit of patients, and not for the benefit of the hospital teaching program or hospital administration.

The proposed regulations, published in July of 1973, refined the definition of a private patient as one:

... not admitted on an emergency basis...seen by a physician (not an intern or resident [who] served as the personal physician in the hospital...The patient receives his principal physician services from his personal physician....^{9/}

The regulation which came to be known as the "fiscal test," however, was the source of considerable controversy. A patient was defined as private if:

The patient is billed charges for physician's services in the setting, and reasonable efforts have been made to collect the charges, including deductible and coinsurance amounts. The obligation to pay the billed charges is demonstrated by the fact that during the preceding hospital accounting period, at least 50 percent of the physician's patients in the same setting paid all or a substantial part of his fees from sources other than public assistance programs. (Medicare patients, for purposes of this rule, will be deemed to have satisfied these

*Related provisions allowed costs to be imputed for the services provided by physicians on a voluntary staff, with Medicare paying its proportionate share of those imputed costs to a fund designated by the organized medical staff and earmarked for the improvement of patient care or for educational or charitable purposes. Another provision made it possible for a medical school to be reimbursed (through the hospital) for services that would be covered if provided by the hospital, if the medical school provided the service and the hospital made payment for the service. Proposed regulations for this provision were published in the Federal Register, March 14, 1975.

requirements if they paid deductible and coinsurance amounts in full or substantial part from private sources and no greater effort was made to collect from them than from other patients.)

The medical community and the hospitals objected to this regulation, arguing that the fiscal test would lock in a dual system of patient care.

The report of the Senate Finance Committee which accompanied the Social Security Amendments of 1972 contains the sentence below, which some interpret as a fiscal test. Others indicate that this does not say that in the absence of meeting presumptive requirements, no fees may be billed.

To facilitate efficient administration, a presumption may be made that all of the patients in an institution, or portion of an institution, are private patients but only where the institution offers satisfactory evidence that all patients are treated the same with respect to arrangements for care and accommodations, that all patients receive their principal physician services from an attending physician, and that all of the patients are billed for professional services and the great majority pay.^{10/}

Proposed regulation number 3 (below) describes the conditions under which it may be presumed that all patients in a hospital or hospital setting are private patients. The requirements in either Test A or Test B must be met.

Test A

All of a hospital's inpatients or outpatients will be deemed to be private patients if the hospital establishes that during a 2-year period ending December 31, 1967, and each year thereafter: (A) all the patients have been regularly billed by the hospital for services rendered by physicians; (B) reasonable efforts have been made to collect in full from all patients; and (C) charges (including applicable deductibles and coinsurance) have been regularly collected in full or in substantial part [later defined as 65 percent] from at least 50 percent of all patients.

Test B

All of the patients in a hospital or hospital setting will be deemed to be private patients during a hospital accounting year if: (A) at least 85 percent of the patients in the setting [are private patients] ... (B) it can be shown that during a representative period of at least 4 consecutive months during the previous hospital accounting period, 50 percent or more of the patients in the setting paid the billed physician fees [in full or substantial part--later defined as 75 percent] from sources other than public medical assistance programs; ... [for Medicare patients, the same rules apply to the payment of deductible and coinsurance amounts,] (C) ability to pay was not

a factor in deciding the status of the patients inside the setting or the services provided by various types of practitioners (for example, ability to pay had no bearing within the setting on the assignment of accommodations, or in the respective roles played by residents, interns, and the personal physician in patient care); and (D) assurance is provided that the foregoing requirements will continue to be met in subsequent accounting periods and appropriate arrangements have been made to notify the intermediary as soon as it appears that the foregoing requirements may not be met for any accounting period.^{11/}

The American Association of Medical Colleges (AAMC), the American Hospital Association (AHA), the AMA, and others who commented on the proposed regulations argued that Test B erroneously incorporated a fiscal requirement intended by the law to be a part of Test A only. They argued further that neither fiscal test was justified on the basis of either the law or legislative history.

The controversy over Section 227, which has been suspended for the duration of this study, and proposed regulations reflects what may be a conflict of objectives. When Medicare and Medicaid were enacted, the objective was to reduce financial barriers to health care for the aged and the poor to enable them to receive health care services in the same manner as the rest of the population. Although these barriers did come down for many of the aged and the poor, the distribution of health services is such that in some areas, a segment of the population continues to receive care as "service" patients in teaching or public hospitals. The problem as the Senate saw it was whether payment should be made on a private patient basis for those not receiving "private" care. Others saw the potential result of the congressional changes, particularly the fiscal test, as locking in a dual system of health care.

AAMC Study

In July, 1973, SSA published the proposed regulations for implementing the 1972 amendments. They generated considerable protest from the medical community. The AAMC, AHA, and AMA criticized the proposed regulations and requested and were granted an extension of the allotted 30-day comment period.

During this time, the AAMC conducted a study^{12/} to assess the "fiscal and programmatic impact" of the proposed regulations on teaching hospitals and medical centers. Six institutions were studied.

Following the study, AAMC pointed out what it considered to be the implications of Section 227. AAMC claimed the new regulations would provide an incentive for physicians to admit their patients to non-teaching settings to avoid the effect of a new reimbursement approach. AAMC charged that the fiscal test, and the possibility of encouraging the establishment of private and nonprivate settings within the same institution, could foster

dual systems of care. Especially significant were the provisions of the regulations that would tend to classify Medicaid patients as nonprivate patients. AAMC noted that the fiscal test would hit especially hard the public teaching hospitals which have been trying to change their image as charity organizations. (It would be difficult for an institution to change from cost-based to fee-for-service reimbursement because a pattern of collection of charges cannot be demonstrated with respect to Medicare patients while their care is being reimbursed on a cost basis.)

The regulations implementing Section 227 were never published in final form. In November, 1973, the Senate Finance Committee requested that a study be conducted by SSA and others in 40 institutions on the appropriate and equitable payment of physicians in teaching hospitals. On December 23, 1973, Congress enacted the Social Security Amendments of 1973, Section 15c of which called for these studies.

STUDY METHOD

To respond to the congressional mandate calling for the study of teaching hospitals, field teams will gather and analyze data and describe the variety of teaching and patient care settings, the organization of medical education, and existing payment mechanisms.

The study group is using two data collection approaches:

- a national survey of teaching hospitals to develop baseline data and a frame of reference for more detailed study (there is no existing consolidated data base on teaching hospitals), and
- an in-depth field study of a sample of medical/osteopathic schools and teaching hospitals.

This information will be used as a base for formulating alternate methods of reimbursement for the services of teaching physicians and house officers, and for assessing the impact of different reimbursement methods on teaching hospitals.

National Survey of Teaching Hospitals

The national survey is being conducted at the request of the staff of the House Ways & Means Committee to provide a general picture of the nation's approximately 1,500 teaching hospitals. The National Survey Questionnaire (NSQ) was sent to all hospitals with one or more graduate education programs approved by the AMA, the AOA, or the ADA.

The NSQ is divided into three parts:

Part I: Hospital Characteristics includes questions on admissions, inpatient days, and outpatient visits by type of payor (Medicare, Medicaid, other public assistance, all other); on number of medical staff by source

of compensation and teaching activities; and on contractual arrangements for physician services.

Part II: Financial Data requests income and expenditure data including patient care revenue by type of payor, house staff expense, payroll expense, and transfers between the hospital and medical schools.

Part III: Educational Programs elicits data on graduate training programs by specialty and subspecialty including the number of training positions offered and filled, the number of foreign medical graduates, and house staff salaries by level and source.

During development of the questionnaire, meetings were held with various groups to identify and clarify questions and to avoid requesting data which were to be collected and published during the survey time frame by other organizations. The questionnaire was reviewed by all members of the Steering Committee, the three advisory committees, and by staff of the AHA, the AAMC, the American Osteopathic Hospital Association (AOHA), and the American Association of Colleges of Osteopathic Medicine (AACOM).

In September, 1974, the survey questionnaire was tested at nine institutions to identify areas that needed further modification. The institutions represented several distinct types of teaching hospitals -- public, private, university-owned hospital, major affiliate of a medical school, and minor affiliate of a medical school. They were located in a large eastern city, a small eastern city, and a large midwestern city. Further revisions were made after the tests and discussions with groups listed above.

The final draft of the questionnaire was completed during the first week of October and the clearance process through SSA and the Office of Management and Budget (OMB) was initiated November 26 after the contract with SSA was signed. The NSQ will be mailed in April 1975.

FIELD STUDIES

Information collected during the field studies will provide the study group with a thorough understanding of the variety of ways that patient care and graduate medical/osteopathic education are carried out in teaching hospitals, the institutional organizations and relationships that are the setting for these activities, and the numerous arrangements that finance them. The information collected will serve as the starting point for analyzing current and proposed reimbursement methods and their effects on patient care, graduate medical education, and teaching hospital organization and financing.

The field work is being conducted in 77 hospitals: 62 hospitals affiliated with medical schools, 7 non-affiliated hospitals, and 8 osteopathic hospitals. (In addition, data will be collected on graduate medical education and financial support of teaching and house staff in 15 VA hospitals affiliated with the medical schools in the sample.) The types of hospitals sampled are shown below:

Location and Status	Public	Nonprofit Voluntary	Total
Northeast			
Affiliated	1	4	5
Non-Affiliated			
Mid Atlantic			
Affiliated	6	17	23
Non-Affiliated		6	6
South			
Affiliated	5	3	8
Non-Affiliated	1	1	2
Southwest			
Affiliated	2	3	5
Non-Affiliated		1	1
Midwest			
Affiliated	5	9	14
Non-Affiliated		4	4
West			
Affiliated	4	5	9
Non-Affiliated			
TOTAL	24	53	77 <u>a/</u>

a/Does not include the 15 affiliated VA hospitals.

Background data for the field team interviews will come from the NSQ. Additional specific information will come from interviews with hospital and medical staff and administrators. Data will be collected in five interrelated areas:

- 1) institutional organization and financing
- 2) graduate medical education programs

- 3) teaching physician activities and compensation
- 4) organization and provision of patient care services
- 5) implementation of current Medicare regulations by intermediaries and carriers

Specific data will be collected as follows:

- Organizational and financial information will be requested and will include questions about the staffing and decisionmaking structure; institutional revenues and expenses, fund flows, billing procedures; size and composition of house officer programs; physician relationships with the medical school, hospital, and practice plan.
- House officer activities will be logged on-site to determine time spent on teaching, education, research, and patient care. Cost and funding of house officer programs will be studied. Financial support of graduate medical education programs will be studied to provide a framework for assessing the fiscal and programmatic impact of alternative reimbursement methods.
- Teaching physician activities, patient care relationships, billing and collecting arrangements, and compensation will be examined. Analysis of compensation patterns will identify compensation sources and methods of physician payment, and employment agreements between physicians and the medical school or hospital.
- Examination of the organization and delivery of patient care will include study of the entry points into patient care systems, assignment of patients to physicians and geographic settings within the hospitals, classification of patients as teaching or non-teaching, if such a distinction exists, relationship of house staff and attending physicians to the patient, payment status of patients, systems used for billing patients and third party payors, and, finally, the systems used for collection and distribution of patient care revenues.
- Medicare intermediaries and carriers will be surveyed to determine how SSA directives are interpreted and implemented.

The field study interview guides and the time logs for recording physician and house officer activities were pretested at three medical schools and their affiliated hospitals and at one non-affiliated hospital in January and February of 1975. They were modified as a consequence of the pretest and were approved by HEW and OMB in March 1975.

The field studies at the 77 hospitals in the sample began in March 1975.

Sample Selection

The teaching hospital sample was designed to collect the maximum feasible amount of information pertinent to the congressional charges calling for

this study. Statisticians on the study staff, working with statisticians on the SSA staff, developed the sampling method. Care was taken to ensure that the sample was representative and random, with limited sampling error. Stratified sampling, with controls beyond stratification, was chosen as the best method for increasing sample precision. The reliability of the statistical inferences was increased by subdividing the population into like groups, making each group as homogeneous as possible, and then drawing separately from each group. The population to be sampled included all established medical/osteopathic schools which had graduated at least one class, and all teaching hospitals.

For purposes of sampling, the population was divided into three subgroups — teaching hospitals affiliated with medical schools, non-affiliated teaching hospitals, and osteopathic teaching hospitals. The osteopathic teaching hospitals were sampled separately to ensure that some were included in the study. The sampling procedures for the three subgroups were as follows:

Affiliated hospitals - Fifteen medical schools were selected from a stratified random sample, with controls beyond stratification. Three stratification criteria were used: geography - the U.S. was subdivided into six geographic regions; medical school ownership -- public or private; and, size of graduate education programs, based on the number of house officers in programs in the hospitals associated with the medical school. The probability of selection of an individual medical school was weighted toward the number of interns and residents within the complex. The number of medical schools to be selected from an individual cell (for example, west, public, large) was also dependent upon the same weighting scheme.

Osteopathic hospitals - The osteopathic hospitals were divided into three groups including the four osteopathic schools that own their hospitals; the three osteopathic schools that do not own their hospitals; and the independent osteopathic hospitals. Eight hospitals and two schools were drawn in this sample.

Non-affiliated teaching hospitals - Seven non-affiliated teaching hospitals were selected. The criteria for the non-affiliated hospitals were: a minimum of 150 beds; a minimum of 15 house officer positions in 1974, and two geographic regions - east and west. Individual hospitals were weighted by the number of interns and residents.

The sample was reviewed by the Steering Committee, AHA, AAMC, AOHA, and AACOM for their judgment and approval. AHA and AAMC have approved the sample of institutions affiliated with their organizations. AOHA and AACOM requested a larger sample (26 of 60 teaching hospitals) than was deemed possible for inclusion by the Steering Committee and staff.

Chapter 3

GEOGRAPHIC AND SPECIALTY DISTRIBUTION OF PHYSICIANS

The Social Security Act Amendments of 1973 include the provision that:

The Secretary of Health, Education, and Welfare shall arrange for the conduct of a study or studies concerning ...the extent to which funds expended under (Titles XVIII and XIX) are supporting the training of medical specialties which are in excess supply, how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty....

In response to this part of the congressional charge, the study group is collecting and analyzing data as to whether "excess supply" can be determined; which geographic areas have low concentrations of physicians and which have high concentrations of physicians; the extent to which Medicare and Medicaid funds support specialty training; and whether other reimbursement methods could affect physician distribution by specialty and geographic area.

DEVELOPMENT OF MEDICAL SPECIALTIES

Medical specialties evolved early in the 20th century in response to rapid growth of medical knowledge. Since no one physician could master the entire body of medical knowledge, it became necessary for some physicians to concentrate their efforts on a particular aspect of medical practice. The early response of organized medicine to specialization led to the current voluntary process for specialty certification.

The American College of Surgeons was the first specialty society to certify members after they passed an examination. Today, specialty boards, which cover about 60 specialties and subspecialties, require both graduate training and examination for certification. In addition, there are newly developed subspecialties with no formal certification process. Some boards assist the Liaison Committee on Graduate Medical Education in review of residency training programs. Approval is based on the quality of education, and although some quantitative limits are set in some specialties, the process does not systematically take into

account whether the graduate medical training process is producing specialties in accord with national manpower needs.*

Although the boards certify specialists, certification is not required for licensure. Theoretically, any physician, with or without board certification, and with or without graduate specialty training, may practice any specialty he wishes. The health care system relies on local hospitals to regulate the practice of specialties by setting criteria for their medical staffs. These criteria may or may not include board certification.

THE DISTRIBUTION OF MEDICAL SPECIALTIES

The number of physicians who designated themselves as general practitioners declined to 15 percent of all physicians in 1973, compared to 76 percent in 1931; there has been a concomitant increase in physicians specializing in internal medicine and pediatrics. These physicians render many primary care services previously assumed by general practitioners, so the actual decrease in the ratio of primary care physicians per 100,000 population between 1931 and 1963 was 30 percent (from 97 per 100,000 to 67 per 100,000 in 1963), and in the past ten years there has been little change in this ratio.^{13/}

Between 1931 and 1963, the number of surgical specialists rose from 11 to 37 per 100,000 population, and by 1973 had reached 44 per 100,000. Between 1931 and 1963, ratios for other specialists (excluding internal medicine, pediatrics, and surgical specialties) rose from 8 to 34 per 100,000, and by 1973, reached 46 per 100,000.^{14/} If these trends continue, HEW has projected that in 1990 the ratios of active physicians per 100,000 population will be 77 primary care physicians, 76 surgical specialists, and 75 other specialists, with an active physician-to-population ratio of 228 per 100,000.^{15/} The current active physician-to-population ratio is 165 per 100,000.^{16/}

If the current trends continue, primary care physicians will increase slightly during the next 15 years. Future primary care physicians will include fewer general practitioners and more primary care specialists such as internists, pediatricians, and family practitioners. At the same time, however, the number of surgical and non-primary care specialists will increase significantly.

GEOGRAPHIC DISTRIBUTION OF PHYSICIANS

Available data show that some geographic areas do not have adequate access to physicians' services. Table 1, which lists physician-to-population ratios by state for 1973, shows that ratios range from 71 physicians per

*It should be noted that there is no accepted public or private organization that determines national manpower needs.

TABLE 1. NON-FEDERAL PATIENT CARE PHYSICIANS

State	Physicians per 100,000 population	Rank of physician-to- population ratio
Alabama	82	47
Alaska	78	49
Arizona	131	14
Arkansas	81	48
California	168	5
Colorado	150	9
Connecticut	169	4
Delaware	121	21
Florida	127	17
Georgia	102	33
Hawaii	140	10
Idaho	87	45
Illinois	125	19
Indiana	92	40
Iowa	89	42
Kansas	104	31
Kentucky	94	38
Louisiana	105	29
Maine	101	34
Maryland	159	6
Massachusetts	177	3
Michigan	114	24
Minnesota	133	12
Mississippi	77	50
Missouri	115	23
Montana	96	37
Nebraska	104	30
Nevada	102	32
New Hampshire	123	20
New Jersey	131	15
New Mexico	97	36
New York	195	2
North Carolina	100	35
North Dakota	85	46
Ohio	119	22
Oklahoma	90	41
Oregon	130	16
Pennsylvania	132	13
Rhode Island	151	8
South Carolina	88	44
South Dakota	71	51
Tennessee	107	27
Texas	107	28
Utah	126	18
Vermont	151	7
Virginia	113	25
Washington	134	11
West Virginia	93	39
Wisconsin	109	26
Wyoming	89	43

Source: G.A. Roback, Distribution of Physicians in the U.S., 1973, American Medical Association (Chicago: American Medical Association, 1974).

100,000 population in South Dakota to 195 per 100,000 in New York. Table 2 shows the distribution of physicians by specialty in the states with the highest and lowest ratios.

Computing physician-to-population ratios for areas as large as states can blur the magnitude of geographic inequities by averaging out very high and very low distribution areas. Computing the ratios on a county by county basis may also be misleading. Although a county may have no physicians, its residents may have a short drive into the next county in which there is an adequate supply of physicians.

FEDERAL EFFORTS TO ENCOURAGE BALANCED DISTRIBUTION

Efforts to increase the total number of physicians through direct support of medical education began in the early 1960s following the recommendation of the Bane Committee.^{17/} On the assumption that more physicians would lessen distribution inequities, the committee recommended increased federal responsibility for construction of medical schools, and loans and scholarships for medical students.

The Health Professions Assistance Act of 1963 provided direct federal support for education in the health professions. To increase the rate of enrollment, in 1965, the Health Professions Educational Assistance Act Amendments were enacted. In 1968, the Health Manpower Act was passed to increase institutional support.

In 1969, HEW reported that the United States needed 50,000 more physicians and 200,000 nurses to meet the health needs of the population.^{18/} In 1970, the Carnegie Commission on Higher Education noted the increased pressure to expand the number of M.D. candidates, stating in addition that medical and dental schools were underfunded and in severe financial difficulty.^{19/}

In response, the Comprehensive Health Manpower Training Act was passed in 1971. It provided grants for annual operating expenses based on capitation per student (a grant based on an amount per student), as well as funds to assist health professional schools to maintain accreditation standards and improve curricula. Requirements for increases in enrollment were attached to the capitation payments. There was a major federal effort to set explicit incentives to improve geographic distribution of physicians by allowing loan forgiveness for those who would agree to practice in shortage areas either by service in the National Health Service Corps or in private practice.

STUDY APPROACHES

The congressional charge assumes a maldistribution of physicians among specialties and geographic areas and requests an analysis of the potential for using reimbursement to influence physician choice of specialty and

TABLE 2. RATIO OF NON-FEDERAL SPECIALISTS TO 100,000 POPULATION

State	Ratio of physicians to population*	Primary care specialties			Selected surgical specialties					
		Internal Medicine	General Practice	Pediatrics	General Surgery	Ob-Gyn	Neurosurgery	Ophthalmology	Orthopedic Surgery	Otolaryngology
<i>Five highest states ranked high to low</i>										
New York	195	35	24	14	20	14	1	6	5	3
Massachusetts	177	35	20	11	19	10	2	6	6	3
Connecticut	169	30	19	12	16	11	2	5	6	3
California	168	24	32	10	14	11	2	6	7	3
Maryland	159	27	19	12	16	14	2	6	4	3
<i>Five lowest states ranked low to high</i>										
South Dakota	71	6	26	2	10	3	**	2	3	1
Mississippi	77	7	23	4	9	6	1	3	3	2
Alaska	78	8	24	6	8	6	1	4	4	2
Arkansas	81	8	27	3	7	4	1	3	3	1
Alabama	82	10	19	5	10	6	1	3	3	2

Source: G.A. Roback, Distribution of Physicians in the U.S., 1973 (Chicago: American Medical Association, 1974).

*Includes physicians reporting "patient care" as primary activity.

**Less than .5 per 100,000.

practice location. The study group is, therefore, addressing interrelated questions: Is there a maldistribution of physicians, and if so, can Medicare and Medicaid reimbursement favorably influence the distribution of physicians?

To determine whether a maldistribution does, in fact exist, it is necessary to develop criteria for appropriate numbers of physicians in a given specialty in a given geographic area. However, since a specialist can be board certified, board eligible (has completed graduate training requirements but has not passed the requisite examination for certification), or self-designated, the definition of a specialist is ambiguous. Furthermore, a specialist may devote all, some, or little of his time to the practice of his designated specialty and may provide care in areas generally associated with another specialty. For example, a general surgeon may treat simple fractures which would normally be classified as orthopedic surgical procedures.

The relationship between specialty distribution and geographic distribution of physicians is complex. Service areas for different specialties vary. Although a primary care physician may draw all of his patients from a neighborhood of one, two, or three square miles, a subspecialist, such as a neurosurgeon, may draw his patients from a state, the entire country, or even from abroad. In assessing the geographic distribution of physicians, it is important to select for analysis geographic areas which correspond to appropriate medical practice or trade areas. Most medical manpower data are based on state and county boundaries which are usually larger than primary care medical trade areas; these data may suffice for tertiary care specialties.

The most direct way to determine the appropriate number or range of medical specialists required for any geographic area would be first to determine the societal needs for the services of each specialty. Assuming the needs for the services could be determined, translation of those needs into manpower required to meet the needs could be attempted through a variety of methods. The basic difficulty inherent in such an approach is in the determination of needs for medical services. The only available proxy for medical needs is demand for services (utilization), and those few demand studies for specialty services currently available indicate great variations in demand among similar populations.

Given the time constraints for this study, there is no simple objective method to measure oversupply or undersupply of physicians. Undersupply might be measured directly if one could determine for specific areas over a period of years those health problems going untreated and why. Some judgments might then be made of the minimum number of physicians in different specialties needed for a specific geographic area.

Oversupply of physicians is difficult to ascertain because of discretion on the part of physicians as to the necessity for medical interventions.

The impact of physician discretion is evident in studies which report up to tenfold differences in the rates of utilization of a specific specialty service in demographically similar areas.^{20/}

These surveys document great variations in the rates of almost all surgical and some medical procedures from one geographic area to another and indicate that determination of physician manpower needs derived from utilization rates would be unreliable.

In the absence of rigorous "needs" analysis, establishment of an optimal geographic and specialty distribution of physicians for a defined geographic area can be attempted through the imposition of value judgments. It is important to emphasize that any effort to establish optimal ratios of specialists-to-population which does rely on value judgments can be challenged by those who do not share any given set of values applied. Given the current limitation on objective evidence for undersupply or oversupply of physicians, efforts to estimate optimal physician distributions using value judgments must precisely define the values imposed on the process.

STUDY METHOD: MANPOWER MODELING

To establish the uncertainty in the current state of the art in manpower modeling, the study group will examine the range of informed opinion on what constitutes undersupply, oversupply, and optimal supply of physicians. This study in manpower modeling will serve as a vehicle for developing new data sources which will allow future health planners to better predict the needs of populations for health services and health manpower.

Panels of experts in the health professions and in manpower planning will be asked the following: Given a fixed supply of physicians in a given geographic area, how should they be distributed by specialty and geography to maintain a balanced, adequate supply of physicians' services?

The panels will include health manpower experts, prepaid group practice physicians, hospital administrators, health planners, physicians in different specialties, primary care physicians, economists, systems analysts, and consumer advocates. Several panels will meet separately to analyze the same areas.

The following limits will be set:

- Specialty distributions will be modeled for specific geographic areas which coincide with representative medical trade areas. The Geographic Division of the U.S. Bureau of the Census is assisting the study group with population mapping and demographic characteristics. Several medical trade areas will be modeled to develop information for areas with different socio-economic makeup. Areas selected are those for which there is in-depth information on the health care system. Area models have been chosen rather than national models because the

latter suffers from the lack of detailed national data on the health services system and does not allow for distributional considerations imposed by geography.

- The development of desired specialty distributions for the selected medical trade areas will be undertaken at two levels, the first based on the current number of physicians, and the second on the increase of physicians in the area proportionate to the national rate of increase. Variables such as increased financial access for primary care, increased number and size of prepaid group practices, and use of ancillary personnel will be introduced in the modeling process in one or two areas.
- The modeling approach will be analyzed from two perspectives — the criteria used by the panels to generate these distributions, and the computed specialty distributions. It is possible that the criteria will prove to be of more general interest for future policy-makers and health planners than the distributions themselves.

This approach will be tested in May 1975 for Arizona. Arizona was selected because of the availability of good state and substate data. A questionnaire has been developed and is being reviewed by several committees before the first panel meeting. The questionnaire provides data on physician manpower in the area by specialty, certain national data, selected health indicators and demographic information, and health facilities information. The questionnaire then seeks the judgments of the panelists on the number of primary care physicians and specialists by specialty and the criteria used to make the judgments. As a second step, geographic constraints are imposed, and finally, variables such as changes in the organization of care are introduced.

STUDY METHOD: REIMBURSEMENT AND PHYSICIAN DISTRIBUTION

To answer the second part of the congressional charge about physician distribution, the study group will examine what part Medicare and Medicaid funds play in the creation or expansion of graduate training programs and in physician choice of practice by specialty and location.

Although the charge is focused on economic factors, other factors may influence physician choice of specialty and geographic location. Several studies have developed correlations among motivational factors in physician practice choice.^{21/}

Several data-gathering approaches will be used to analyze the potential influence of reimbursement on specialty training and physician distribution. Part III of the study group's National Survey Questionnaire (described in Chapter 2) will provide national data about current specialty and subspecialty training programs, including such variables as age of program, trends concerning number of positions offered and filled, and sources of

funds for program support. The data will also elicit information on training programs by ownership of hospital, institution size, affiliation with medical schools, and geographic distribution of training programs. Financial data will be collected on house officer stipends and the sources of support for these stipends. The questionnaire will be sent to all hospitals with approved training programs.

In addition, in over 70 hospitals selected for in-depth study, factors which influence decisions to institute a new training program or a change in size of an established one will be examined. Interviews with program directors, hospital administrators, hospital financial officers, and house staff, combined with analysis of hospital budgets, will provide data for determining the influence of Medicare and Medicaid funds on graduate training programs. Special attention will be given to differences in support for ambulatory care specialties and hospital-based specialties.

The coverage and levels of support of public and private insurance for outpatient care may make it difficult to support and expand training programs in primary care. Health insurance has traditionally supported inpatient care, including surgery, laboratory, and x-ray fees, and provided proportionately less extensive coverage for outpatient care, often with higher deductibles and coinsurance than for inpatient care and surgery. Both the National Survey Questionnaire and the field studies will explore differences in support of training programs.

Reimbursement through Medicare and Medicaid will be analyzed in various parts of the country to determine reimbursement effects on geographic distribution of physicians and differences between specialists and generalists. Payments for physician services are reimbursed under Part B of Medicare and often are based on usual and customary fees prevailing in designated medical trade areas. Medicare adopted the method of payment used by most private insurance companies and Blue Shield plans in 1965. Usual and customary fees may have reflected differences in per capita incomes in different parts of the country, with some indication that lower fees generally correlate with lower income areas. The Social Security Administration developed a questionnaire that went to all carriers in the country to collect prevailing fees for 39 procedures by geographic area. This data will be used by the study group.

Medicaid reimbursement for physician services is established by the states. Fee policy and levels vary from state to state. In some states Medicaid uses the Medicare levels; in others, there are statewide or substate fee schedules; in others, private insurance fees are used. In cooperation with the Medical Services Administration of the Social and Rehabilitation Services Administration, the study group has developed a questionnaire to be sent to all Medicaid state agencies. The questionnaire will collect information from the states on their reimbursement policies and fees for approximately 15 procedures, and fee differences in different geographic areas. Medicare and Medicaid fees will be analyzed to determine whether

there are real or potential financial deterrents or incentives for physicians to practice in one area rather than another, or to enter particular specialties.

Medicare and Medicaid fee data will not provide total physician income data. Conclusions will be difficult to draw without analysis of income differences that result from the total fees received from all sources by specialty and geography. The study group has explored the availability of income data by specialty and geography. Although there are some data on income differences by specialty and broad geographic regions,²² the study group does not have access to data on total income by specialty and geographic area. The study group will continue to explore all possible data sources.

Chapter 4

FOREIGN MEDICAL GRADUATES IN THE UNITED STATES

The Social Security Amendments of 1973 include the provision that:

The Secretary of Health, Education, and Welfare shall arrange for the conduct of a study or studies concerning ...the extent to which such funds (under Titles XVIII and XIX) support or encourage teaching programs which tend to disproportionately attract foreign medical graduates....

The specific issue raised by this charge is the influence, if any, of Medicare and Medicaid reimbursement on the distribution of foreign medical graduates (FMGs) in teaching programs and specialties. The issue is an integral part of the more general question concerning the impact of reimbursement on the creation and support of house officer programs in teaching hospitals.

In this study, an FMG is defined as a graduate of a medical school located outside the United States, Canada, or Puerto Rico who has entered the U.S. as an immigrant physician or an exchange visitor physician. A subgroup of FMGs are the U.S. foreign medical graduates, American nationals who receive training abroad.

FMG PUBLIC POLICY ISSUES

Studies conducted in the last ten years by professional medical organizations and the federal government and recently proposed congressional legislation indicate widespread concern about the role of FMGs in the health care system in this country.

Legislation passed in the last fifteen years has permitted large increases in the number of foreign-trained physicians and surgeons entering the U.S. In 1963, the number of known FMGs in the U.S. was 31,000.^{23/} The 69,000 FMGs listed in the AMA registry of physicians as of December, 1973, comprised 20 percent of all active physicians in the U.S.^{24/} The main

activity of about 90 percent was patient care. About 10 percent were involved in medical education, research, and other non-patient care activities.^{25/} Twenty-eight percent of FMGs were in graduate training programs, where they now constitute one-third of all interns and residents in filled, approved programs (Table 1). In 1972, FMGs comprised 46 percent of new licentiates. In 1973, 7,419, or 44 percent of all additions to the medical profession were FMGs (Table 2).

FMGs enter the U.S. to fill vacant hospital house staff positions. Each year the number of vacancies exceeds the number of U.S. medical graduates. There is presently no accepted system for linking graduate training and house officer positions to the supply of U.S. medical graduates. The Liaison Committee on Graduate Medical Education, which approves hospital internship and residency programs, controls the quality of the programs, but not the total number of house staff positions offered by hospitals. As a result, there are more approved internships and residencies offered each year than U.S.-trained physicians available to fill them.

Other issues raised by health professionals and health care groups include concern about the training received in some foreign medical schools, acculturation of FMGs, and the "brain drain" from countries where medical manpower is in short supply.

With no single national agency responsible for controlling physician immigration, professional medical groups and individual state medical boards have devised procedures for professional testing, evaluation, and licensure of FMGs separate from those required for U.S. medical graduates. The Educational Commission for Foreign Medical Graduates (ECFMG) administers an examination which has been increasingly criticized for its failure to ensure that all FMGs meet education standards comparable to those required of U.S. medical graduates.

EDUCATION EXCHANGE AND IMMIGRATION LEGISLATION

FMGs enter the U.S. either as exchange visitors or immigrants. Successive changes in international education exchange programs and immigration legislation have encouraged admission of FMGs into the U.S.

Although the intent of the Exchange Visitor Act was to promote international understanding through education and cultural exchange, and the objective was to have foreign exchange visitors return to their homelands using the knowledge they acquired in the U.S., many FMGs have used the exchange programs to gain graduate medical education; they then apply for citizenship, rather than return to their native countries to practice medicine.*

*In 1961, the Fulbright-Hays Act (P.L. 87-256) became the blanket legislation covering prior exchange visitor program laws.

TABLE 1. PERCENT FMGS IN FILLED RESIDENCY POSITIONS*

Specialty	1963	1964	1965	1966	1967	1968	1970**	1971	1972
Total number FMGs in residencies	7,062	8,140	9,113	9,483	10,605	11,201	12,943	13,520	14,440
Anesthesiology	38	39	46	50	50	50	52	54	58
Child psychiatry	17	19	23	22	21	19	24	25	27
Colon and rectal surgery	50	47	64	67	61	55	55	44	65
Dermatology	11	13	12	11	10	9	12	8	9
Family practice	-	-	-	-	-	-	11	11	12
General practice	52	63	66	67	65	55	69	70	79
Internal medicine	23	25	28	30	34	35	35	35	35
Neurological surgery	16	18	17	17	21	22	24	22	20
Neurology	22	24	24	27	28	26	29	30	27
Obstetrics and gynecology	22	25	27	30	33	37	40	40	39
Ophthalmology	8	10	9	9	8	7	8	8	8
Orthopedic surgery	11	12	13	13	15	12	11	9	11
Otolaryngology	11	14	12	12	11	12	14	16	17
Pathology	34	37	40	42	46	48	54	55	56
Pediatrics	33	37	41	39	39	42	42	38	37
Pediatric allergy	26	22	35	31	25	22	38	17	23
Pediatric cardiology	36	49	54	52	65	53	54	39	39
Physical medicine	30	35	44	44	50	40	62	59	61
Plastic surgery	13	27	21	16	24	22	20	21	24
Psychiatry	24	25	27	27	29	29	28	27	27
Radiology	17	17	18	18	20	20	19	21	27
Surgery	27	30	32	35	36	37	39	38	38
Thoracic surgery	30	37	38	38	43	44	39	43	36
Urology	16	19	23	24	24	25	28	25	22
Total	24	26	29	30	32	32	33	32	32

Source: American Medical Association, Directory of Approved Internships and Residencies (Chicago: American Medical Association, for years shown).

*This table includes residents in hospital positions only.

**Figures for 1969 are not available.

TABLE 2. GRADUATES OF FOREIGN MEDICAL SCHOOLS
 INITIALLY LICENSED IN 1973

State	Total
Alabama	2
Alaska	2
Arizona	22
Arkansas	9
California	202
Colorado	15
Connecticut	20
Delaware	33
District of Columbia	153
Florida	348
Georgia	16
Hawaii	5
Idaho	0
Illinois	766
Indiana	16
Iowa	35
Kansas	26
Kentucky	75
Louisiana	17
Maine	216
Maryland	212
Massachusetts	145
Michigan	844
Minnesota	86
Mississippi	3
Missouri	204
Montana	5
Nebraska	5
Nevada	2
New Hampshire	18
New Jersey	192
New Mexico	23
New York	1,426
North Carolina	63
North Dakota	65
Ohio	348
Oklahoma	36
Oregon	4
Pennsylvania	938
Puerto Rico	117
Rhode Island	23
South Carolina	4
South Dakota	14
Tennessee	19
Texas	123
Utah	5
Vermont	104
Virgin Islands	2
Virginia	244
Washington	88
West Virginia	48
Wisconsin	28
Wyoming	3
Total	7,419

Source: AMA Council on Medical Education, Medical Licensure for 1973, (Chicago: American Medical Association, 1974.)

The Immigration and Nationality Act Amendments of 1965 abolished the national origins quota system and offered preferential treatment of immigrants in employment categories declared to be in short supply. The U.S. Department of Labor has declared a shortage of physicians.

Since 1965, the number of FMGs entering the U.S. as immigrants has risen from 2,000 to 7,119 in 1973; physicians from Asian countries, which had previously had very small immigrant quotas, rose from 205 in 1965 to 4,996 in 1972.²⁶⁷

According to the Immigration and Naturalization Service, by 1971, more foreign physicians were entering the U.S. through the immigration route than were using the education exchange route. Effective in 1972, the 1970 amendments to the Immigration and Nationality Act eliminated a previous requirement that all exchange visitors leave the U.S. for two years after completion of their studies.

LICENSURE

To be admitted to an approved internship or residency program, an FMG must have graduated from a medical school listed in the World Health Organization's Directory of Medical Schools, be eligible for licensure in the country where he was trained, and be certified by the ECFMG.* Certification by the ECFMG, one or two years of graduate training, and passage of a state qualifying examination are basic licensure requirements for FMGs in most states. The Federation Licensing Examination (FLEX) has been adopted by all states (except Florida and Texas) as a standard licensing examination for all medical graduates to replace individual state examinations.

Some states have passed legislation permitting physicians, such as FMGs, who cannot otherwise meet requirements for regular licensure, to be issued limited licenses, provided that their practice is conducted in either long-term tuberculosis or mental hospitals or in geographic areas declared to be underserved. Physicians who hold limited licenses presumably work under the supervision of a fully licensed physician within the hospital. Although arrangements are intended to be short-term until fully licensed physicians can be found for the positions, some states depend heavily on FMGs to staff their hospitals.

*According to the ECFMG, each year between 1970 and 1973, more than 30,000 FMGs took the ECFMG exam. Evaluations of the test results show that one-third to three-fifths of the candidates do not pass initially, and many take the examination several times before passing. In 1973, almost 38,000 FMGs took the examination with a passing rate of 33 percent.

DISTRIBUTION OF FMGS

In 1970, FMGs constituted almost one-third of all physicians in hospital-based practice.^{27/} In 1972, they represented 29 percent of house staff in affiliated hospitals, compared to 64 percent of house staff in non-affiliated hospitals.^{28/} As of 1973, there were 56,244 filled, approved internship and residency positions in the U.S., of which FMGs held more than 18,000.^{29/} They filled more than 50 percent of available graduate training positions in anesthesiology, colon and rectal surgery, general practice,* pathology, and physical medicine.^{30/}

If FMGs in approved training programs are analyzed as a total group separate from U.S. medical graduates, for the most part they choose to specialize in a pattern similar to licensed U.S. medical graduates. The major differences are that FMGs are in higher concentrations in anesthesiology, pathology, and general surgery, and U.S. medical graduates are in higher concentrations in diagnostic radiology, ophthalmology, orthopedic surgery, and family practice.

The state-by-state distribution of FMGs in approved training programs is shown in Table 3.

RECOMMENDATIONS OF OTHER STUDY GROUPS

In 1967, the Panel on Foreign Medical Graduates of the National Advisory Commission on Health Manpower^{31/} issued a set of recommendations to increase the number of U.S.-trained physicians and to ensure that FMGs receive graduate medical education in the U.S. comparable to that received by U.S. medical graduates.

In 1973, the Committee on Goals and Priorities of the National Board of Medical Examiners^{32/} recommended a uniform system of examinations be given to all medical school graduates for entrance into graduate medical education programs. For FMGs, the committee recommended design of a new evaluation instrument to assess more fully English language capability and potential adjustment to the U.S. medical education and health care delivery systems.

Included in recommendations issued by the Association of American Medical Colleges in its 1974 FMG Task Force Report^{33/} were that U.S. medical schools become the source for educating physicians to meet U.S. needs, and a new universal qualifying examination be adopted.

*The number of FMGs in general practice residencies does not apply to family practice residencies. There are few FMGs in family practice residencies.

**TABLE 3. STATES RANKED BY NUMBER OF FMG HOUSE OFFICERS IN FILLED APPROVED POSITIONS
 (as of September 1, 1974)**

State	Number	Percent of state total	Total filled positions
Total	18,033	32	55,496
New York	5,206	52	10,066
Illinois	1,853	56	3,320
Ohio	1,346	45	2,989
Pennsylvania	1,205	33	3,640
Michigan	1,067	44	2,410
New Jersey	1,052	80	1,316
Massachusetts	750	32	2,369
Maryland	693	44	1,559
Connecticut	553	49	1,133
Missouri	503	34	1,498
Texas	411	18	2,345
California	390	6	5,997
District of Columbia	384	27	1,404
Florida	337	27	1,252
Wisconsin	227	28	798
Minnesota	218	16	1,387
Virginia	193	18	1,044
Tennessee	141	15	966
Rhode Island	133	53	252
Louisiana	125	15	826
Kentucky	106	23	459
West Virginia	105	49	214
Georgia	99	13	749
Arizona	94	30	317
Iowa	87	18	475
North Carolina	82	9	896
Indiana	81	14	599
Kansas	74	18	401
Washington	69	10	659
Hawaii	59	22	269
Colorado	58	7	789
Alabama	51	11	456
Oklahoma	46	14	333
South Carolina	43	13	329
Delaware	40	48	83
Nebraska	32	11	282
Oregon	29	7	400
Utah	16	6	253
New Hampshire	13	10	130
New Mexico	13	6	202
Mississippi	12	5	237
South Dakota	12	52	23
Arkansas	9	4	221
Vermont	8	6	133
Maine	4	6	63
North Dakota	3	2	12
Nevada	1	100	1

Source: American Medical Association, Directory of Approved Internships and Residencies, 1973-74 (Chicago: American Medical Association, 1974).

PROPOSED LEGISLATION

Two bills submitted, but not enacted, in the 93rd Congress would have affected the number of FMGs in the U.S. They were H.R. 14356, sponsored by Congressman Roy and S.3585, sponsored by Senator Kennedy and amended by Senator Beall. The Roy bill was aimed at limiting the number of first year graduate training positions to 110 percent of the annual number of United States medical graduates. The annual number of FMGs entering the country has already surpassed^{34/} the annual physician output by U.S. medical schools; the Roy bill probably would curtail FMG immigration and would have the effect of restricting the number of internship and residency positions available for graduates of foreign medical schools.

The Kennedy-Beall legislation would not directly place numerical limitations on FMGs entering the United States. It would require passage of Part II of the National Board Examination and an oral and written English examination.

Identical bills were reintroduced in the 94th Congress.

On March 26th, the House Committee on Interstate and Foreign Commerce reported out H.R. 5546. This legislation would limit the number of first year graduate training positions in 1976 to 155 percent of the number of graduates of U.S. medical schools. This would decrease to 140 percent in 1977 and 125 percent in 1979.

STUDY METHOD

To analyze what effects Medicare and Medicaid funds have on the distribution of FMGs in teaching programs and specialties, it is necessary to determine the distribution of FMGs and U.S. medical graduates in specialties and training programs by geographic areas and the extent to which Medicare and Medicaid reimbursement are factors in the establishment and growth of specialty training programs.

The congressional charge requires specifically that the study group identify those training programs which "disproportionately attract" FMGs. These programs will be defined as:

- specialty programs and teaching hospitals in which the proportion of FMGs in relation to the total of FMGs is greater than the corresponding ratio for U.S. graduates; and,
- specialty programs and teaching hospitals in which the proportion of FMG graduate trainees is greater than their proportion across all programs.

A review of the literature suggests that such factors as licensing requirements influence eventual location of FMGs. Data from the ECFMG, which sets the basic qualifying examination for entry into an approved

graduate training program, will be analyzed to determine the placement of FMGs in training programs. Federal and state licensing laws will be analyzed to determine their effects on FMG location decisions.

Special Studies

In addition to examining the relationship of reimbursement issues as they affect house staff in approved training programs, the study group will analyze the use of these funds where there are no approved programs and where FMGs are employed. The costs of services provided by licensed trainees in such programs are reimbursable under Part B of Medicare; education costs for these programs, however, are not reimbursable.

The National Survey Questionnaire will be sent to hospitals that have been identified by the study group as institutions which employ FMGs but do not have teaching programs according to published data.

Data on numbers and location of FMGs in the U.S. are incomplete. The AMA's master file is considered the most comprehensive source of physician data, but it includes data for the most part on those foreign-trained physicians certified by the ECFMG or fully licensed to practice. There is incomplete reporting in the AMA files on FMGs in the health care field who are not fully licensed or certified by the ECFMG. As a result, there are no hard statistics on the number of unlicensed FMGs functioning in some medical capacity in such places as institutions for the chronically ill and state mental hospitals. The Immigration and Naturalization Service records FMGs as they enter but does not record exits. The ECFMG has complete information on the exchange visitor FMGs it sponsors, but this does not include those who entered as immigrants and covers only 1973 and 1974.

Data gathered during the field studies and from the National Survey Questionnaire will add new information to that already available about FMGs.

Chapter 5

STUDY TIMETABLE

According to the congressional authorization for this study, a final report is to be submitted to Congress and the Department of Health, Education, and Welfare in March 1976. This chapter describes the organization of the study and outlines the timetable for meeting that deadline.

STUDY ORGANIZATION

As in all studies conducted by the Institute of Medicine, National Academy of Sciences, a Steering Committee provides policy guidance to the staff. In addition, for this study there are three advisory committees. They are the Advisory Committees on Specialty and Geographic Distribution of Physicians, Teaching Hospitals, and Foreign Medical Graduates. Advisory committee members include individuals selected from recommendations of organizations interested in the substance of the study. These committees provide technical assistance to the study staff and Steering Committee on issues relating to the different parts of the study.

The staff is organized into three divisions: teaching physician and house officer studies; manpower analysis; and manpower modeling.

WORK PLAN

On June 27, 1974, a letter of agreement was signed with the Social Security Administration to begin the developmental phases of the study. Between July and December 1974, staff were recruited and trained, study methods developed, teaching hospital sample drawn, data collection instruments designed, and pretesting started. The final contract with the Social Security Administration for conduct of the studies was signed on November 26, 1974.

In-depth studies of the 77 teaching hospitals are being conducted by seven staff field teams between March 3 and June 15, 1975. Study methods were pretested in January and February of 1975. Final clearance of data instruments was completed in March. The National Survey Questionnaire will be mailed in April 1975, and as responses are received the study group will begin preliminary analyses. Pretests of the questionnaires were completed in September 1974.

Much of the data gathered in the field studies and the National Survey Questionnaire will be used to analyze the manpower distribution reimbursement questions raised in the congressional charge. Between September 1974 and March 1975, a manpower analysis group developed several techniques for approaches to these questions, and began gathering data from the prevailing screen surveys of Medicare. The Medicaid questionnaire was developed by staff in January 1975 and review by the Medical Services Administration is almost complete.

Manpower modeling was designed between August 1974 and March 1975. Following pretests in March, the first modeling effort, in Arizona, will take place in May. Approximately five other areas will be modeled during the summer and early fall.

Upon completion of the field work in June 1975, intense data analysis will begin. From November through the end of January 1976, data analysis will be completed; the final report will be written and reviewed by the Steering Committee.

All reports prepared by the Institute of Medicine receive independent reviews by the Institute of Medicine and the National Academy of Sciences Report Review Committees. They will review the final report in early 1976.

The final report will be submitted to Congress and to HEW in March 1976.

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GLOSSARY

CAPITATION. Payment in advance and on a regular basis to a health maintenance organization or other health services organization providing for a stipulated scope of services to individuals. The payment is not based on individual procedures or visits.

CAPITATION GRANT. A form of government financial support for health professional schools based on their number of students or graduates.

CARE, AMBULATORY. Care of the type usually provided in the physician's office, clinic, health center, or outpatient department. For the most part this is care of the patient who is not bed-ridden, although occasionally a few beds are provided for short stays, usually for observation.

CARE, EMERGENCY. Care for patients with severe, life-threatening, or potentially disabling conditions that require medical intervention within minutes or hours.

CARE, PRIMARY. The care of patients with general undifferentiated, early symptoms and problems who want to consult sources of general medical care. A relatively few diagnoses produce about 80 to 90 percent of all medical morbidity and engage the bulk of the efforts of all physicians in all forms of medical practice, but particularly the efforts of both general practitioners and family practitioners, and pediatricians and general internists. This aspect of care requires skills in patient care and management. It is provided largely through ambulatory facilities, and includes anticipatory care, rehabilitative care, and terminal care.

CARE, SECONDARY. Diagnostic and consultant care for patients who are referred by community practitioners and agencies for diagnostic evaluation and recommendations for treatment and management that will confirm or modify the original physician's impression. Such patients are customarily seen only on referral and should, in most instances, be referred back to their original physicians for continuing care or to specialists for more specialized care.

CARE, TERTIARY. Care for patients with unusual, complicated, or severe problems that can best be handled by clinical scientists in large, sophisticated medical centers who are deeply involved in the study of specialized disease processes. The different diseases encompassed in this category are numerous (perhaps as much as 90 percent of all known diagnoses), but they occur infrequently and account for perhaps 5 to 10 percent of all morbidity in the community.

CARRIERS. Organizations with whom the Social Security Administration contracts to determine reasonable charges for physicians' services, to review claims, and to make payment to physicians or Medicare beneficiaries and for other services covered under Part B of Medicare.

CHARGES, CUSTOMARY. Median of the charges billed by a physician for performance of a specific procedure.

CHARGES, PREVAILING. Statistically determined limit on reimbursement to physicians in a locality for a specific procedure based on the charges of physicians in similar specialties in the locality.

CHARGES, REASONABLE. Amount to be reimbursed under Part B of Medicare. That amount is either the actual charge for the service, the physician's customary charge, or the prevailing charge in the locality, whichever is least, and whichever would not exceed payment for similar services covered under the carrier's policy which is comparable to Medicare.

COINSURANCE. A provision of some health insurance policies whereby beneficiaries remain liable for a specified percentage of the bill for "covered" services. If policy or plan pays 80 percent of bill and beneficiary is liable for remaining 20 percent, there is a 20 percent coinsurance.

COORDINATING COUNCIL FOR MEDICAL EDUCATION. Was established for the purposes of coordinating accreditation of programs for education of the physician and other health professionals. The CCME supervises activities of the Liaison Committee on Graduate Medical Education, the Liaison Committee on Medical Education (undergraduate), and in the future may develop a Liaison Committee on Allied Health Education, and a Liaison Committee on Continuing Medical Education. The five parent bodies of the CCME are the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies.

COST, REASONABLE. (See Reimbursement, Cost-based.)

DEDUCTIBLE. A provision of some health insurance policies under which benefit protection begins only after the beneficiary has incurred a specified dollar amount (which remains his responsibility) in covered health care expenses.

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG). An independent organization which provides examinations to and gathers data about foreign medical graduates entering approved programs of graduate medical education in U.S. hospitals. The Commission, established in July 1974, is the result of a merger between the Educational Council for Foreign Medical Graduates, and the Commission on Foreign Medical Graduates.

FEDERATION LICENSURE EXAMINATION (FLEX). A standardized medical licensing examination developed in 1968 by the Federation of State Medical Boards in an effort to standardize widely varying state licensing requirements. FLEX is open to U.S. medical school graduates and to FMGs and is designed for physicians in house staff positions or already in practice. Each state can determine its own passing grade.

FELLOW (MID OR POST RESIDENCY). A graduate of a medical/osteopathic/dental school who has had an advanced period of graduate training and is in a fellowship program in a subspecialty or in a clinical research program.

HOSPITAL, AFFILIATED. A hospital affiliated with a medical school which provides the clinical setting for the medical school's training programs at the undergraduate or graduate levels.

HOSPITAL, NON-AFFILIATED. A teaching hospital that has a free-standing program not associated with a medical school.

HOSPITAL, TEACHING. A hospital in which there are AMA, ADA, or AOA approved programs of physician education for medical students and/or interns and residents. Institutions having only programs of continuing education for practicing physicians are not generally regarded as teaching hospitals.

HOUSE OFFICER (HOUSE STAFF). A medical/osteopathic/dental school graduate intern, resident, or fellow in a program of clinical training, service, and research.

INTERMEDIARY (FISCAL INTERMEDIARIES). A national, state, or public or private agency or organization with whom the Social Security Administration contracts to pay for services provided by hospitals and other providers, and certain suppliers of service. They are nominated by the providers.

INTERN. A graduate of a medical/osteopathic/dental school serving a first year period of graduate clinical training.

LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION. As of January 1, 1975, actions taken by the residency review committees are subject to evaluation by the LCGME before program directors can be notified of the actions taken on their programs. The five parent bodies of the LCGME are the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies.

LICENSURE, LIMITED. Licensure for physicians which restricts practice to a specific institution (such as a mental hospital) designated by the state. These are often FMGs.

MEDICAL GRADUATE, FOREIGN (FMG). A graduate of a medical school outside the U.S., Puerto Rico, or Canada who was not a U.S. or Canadian citizen at the time of graduation.

MEDICAL GRADUATE, UNITED STATES FOREIGN (USFMG). A graduate of a medical school outside the U.S., Puerto Rico, or Canada who was a U.S. citizen at the time of graduation.

MEDICAL GRADUATE, UNITED STATES (USMG). Any graduate of U.S., Puerto Rican or Canadian medical school irrespective of citizenship.

MEDICAL SERVICE PLAN. An organization for the billing, collection, distribution and/or use of all specifically identified portions of the professional fees covered by participating physicians.

MEDICAL TRADE AREA. A geographic area that serves as the basis for the organization of health care services and/or the establishment of prevailing charges.

PRACTICE PLAN. (See Medical Service Plan.)

PROVIDERS OF SERVICE. Hospitals, skilled nursing facilities and home health agencies.

PHYSICIAN, ATTENDING. The physician who has legal responsibility for the care given a patient in a hospital.

PHYSICIAN, COMMUNITY-BASED. Performs services primarily in a private office setting, health maintenance organization, or the community.

PHYSICIAN, HOSPITAL-BASED. Physician whose practice is primarily centered in a hospital. May be salaried by the hospital or be compensated through other hospital-related arrangements. Often in pathology, anesthesiology, radiology, and physical medicine. The number of hospital-based physicians in other specialties is increasing.

PHYSICIAN, TEACHING. Physicians who have primary responsibility for teaching activities related to graduate physicians in training or medical/osteopathic/dental undergraduate students in an identified clinical service.

REIMBURSEMENT, COST-BASED. Payment to hospitals and other providers of service based on a formula which meets the costs necessary for the efficient delivery of needed health services to beneficiaries, yet remain within certain limits defined by legislation or regulation. Under Medicare, Part A services--including those provided by interns and residents in approved training programs--are reimbursed on a cost basis. Also reimbursable to the hospital under Part A are the teaching, administrative, and supervising activities of physicians not in training.

REIMBURSEMENT, FEE-FOR-SERVICE. Payment of a fee to a physician for the performance of a specific service or procedure to a patient.

RESIDENT. A graduate of a medical/osteopathic/dental school serving an advanced period of graduate training. (This may represent the first year of graduate training or any year thereafter.)

TEST, FISCAL. Guidelines established by the Social Security Administration which describe the obligations and the extent of financial participation of patients in paying for physician services in a teaching setting.

TEST, PROFESSIONAL. Guidelines established by the Social Security Administration which establish criteria for the payment of physicians on a fee-for-service basis in a teaching setting.

THIRD PARTY PAYORS. Public agencies and private organizations which pay for services provided by physicians, hospitals and other institutions; i.e., health insurance companies, Blue Cross, Blue Shield, Medicare and Medicaid.

TRAINING PROGRAM, APPROVED. Any graduate physician training program for interns and/or residents which is approved by the Liaison Committee on Graduate Medical Education, the Committee of Post Doctoral Education of the American Osteopathic Association, or the Council on Dental Education of the American Dental Association.

TRAINING PROGRAM, NON-APPROVED. A graduate physician training program that has not received or has not sought approval from the Liaison Committee on Graduate Medical Education, the Committee of Post Doctoral Education of the American Osteopathic Association, or the Council on Dental Education of the American Dental Association.

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